Twenty-Third Amendment to the Contract

This Twenty-Third Amendment to the Contract for Iowa Medicaid Enterprise Services (the "Contract") between the State of Iowa, Department of Human Services (the "Agency" or "DHS") and Telligen, Inc., (the "Contractor") is made pursuant to Section 22.5 of the Contract. This Amendment is effective as of March 1, 2016, and will remain coterminous with the Contract. The Amendment modifies, to the extent specified below, the terms and conditions of the Contract:

Section 1: Background

The parties are amending the Contract to reflect the delay in Medicaid modernization, with a new expected "go live" date of April 1, 2016 for implementation of modernization efforts. This amendment accommodates a reduction in volume of Contractor services beginning the month of "go live," and therefore expected in April 2016, and running through the end of the Contract.

Section 2: Amendment to Contract Language

The Contract is amended as follows:

Revision 1: The document titled "Exhibit A," which was incorporated into the Contract through Amendment 22, is hereby deleted and replaced with the attached "Exhibit A." The clauses set forth in Exhibit A amend and/or replace all of Contractor's scope of work as set forth in Section 6.2 of the RFP.

Revision 2: Section 7.1, Performance Based Contract, paragraphs added through Amendment 21 and 22 beginning, "Notwithstanding the above," and ending with "If two or more MCOs are not ready, the parties shall work in good faith to identify and address impacts to scope, timing and fees, and execute an amendment to the contract," are hereby deleted in their entirety..

Revision 3: Section 7.1, Performance Based Contract, is hereby amended by adding the following language at the end of the Section:

Notwithstanding the above, Contractor shall also be entitled to receive the following: $90 per completion of each Inpatient Psychiatric Services Prior Authorization.

Notwithstanding the above, the above payment obligations shall terminate as of April 1, 2016. The following paragraphs establish the payment obligations for any period remaining under the Contract beginning April 1, 2016.

A. For the scope of work set forth in Section 6.2.11, Contractor shall be entitled to receive the following amounts, prorated based on the start date of the project staff set forth in 6.2.11.2.a:

SFY15	$174,066.67
SFY16	$511,403.75
SFY17	$647,842.50
SFY18	$660,798.33
SFY19	$389,943.75

Payment for services within SFY16 through SFY19 of the Section 6.2.11 scope is contingent upon continuance of federal funding for the grant and extension of this Contract. Contractor shall invoice monthly, in amounts consistent with the grant budget narrative but not to exceed the amounts listed above.

B. For services as set forth in RFP Section 6.2 (excluding subsection 6.2.11, which is addressed in Contract Section 7.1(A) above), the Agency will pay Contract based on a mix of fixed price, hourly rate, and unit price for work completed. Table 1 immediately below sets forth the pricing matrix for services.

Table 1: Medicaid Modernization Post-Implementation Payment Table

Scope provision	Description	Basis of Payment	Projected Volume (SFY16 figures are April 1 – June 30)
6.2.1	Medical Support	$209,000 per month through June 2016. $175,000 per month thereafter	n/a
6.2.2.2(b)(5)	CHSC electronic PA summary	Hourly based on Hourly Rate Table 2	Hours: SFY 2016 = 10 SFY 2017 = 40
6.2.2.2(e)	Coordination of services – special needs children/EPSDT	Hourly based on Hourly Rate Table 2	Hours: SFY 2016 = 10 SFY 2017 = 40
6.2.3.2(b) and (z)	Medical PAs	$9 for each completed Medical PA assigned by the Agency.	Completed PAs: SFY 2016 = 6,159 SFY 2017 = 24,634
6.2.3.2(aa)	Complex medical conditions and HCBS waiver PAs	$70 for each completed PA assigned by the Agency	Completed PAs: SFY 2016 = 104 SFY 2017 = 416
6.2.3.2(bb)	Behavioral health PAs	$90 for each PA assigned by the Agency	Completed PAs: SFY 2016 = 90 SFY 2017 = 360
6.2.4.2 (a) through (m), (o) through (u), and (w) through (y)	Long-term care reviews	$277 per completed review	Completed Reviews: SFY 2016 = 4,000 SFY 2017 = 16,000
6.2.4.2(n)	PACE quality assurance and compliance monitoring	$18,397.50 per month	n/a
6.2.4.2(v)	MDS Section Q intake and referral for the full population	Hourly rate as set forth in Table 2	Hours: SFY 2016 = 28 SFY 2017 = 111
6.2.6	Health Information Tech. services	$16,335 per month	n/a

6.2.7	Medical Home Program	$14,833.33 per month	n/a
6.2.8	ICD-10 Testing	Hourly based on Hourly Rate table, with hours performed by a Quality Analyst Engineer.	Hours: SFY 2016 = 20 SFY 2017 = 80

Table 2: Medicaid Modernization Post-Implementation Hourly Rate Table

Title	Hourly Rates
Review Assistant I	45
Review Assistant II	50
Health Data Analyst	75
Quality Analyst Engineer	85
SR Review Coordinator	90
SR Health Data Analyst	90
SR Business Analyst	110
Quality Improvement Manager	125
Database Assistant IV	130
Lead Technical	140
Biostatistician	125
Manager	125
Director	150
SR Director	175
Vice President	250

All hours incurred shall be billed in 15-minute increments.

C. During the following State Fiscal Years, Contractor shall not invoice the Department for any amounts in excess of the following "not to exceed" values without prior amendment to this Contract. The Contractor will bill monthly and notify the Agency when 75% and again when 90% of the NTE amount is expended related to each scope provision. The parties will evaluate the work remaining and determine if any adjustments to the scope of work or budget are necessary.

SFY2016	$13,180,040
SFY2017	$ 8,084,649

MCO Non-Readiness Mitigation Plan:

- In the event that one or more MCOs is/are not fully functional on April 1, 2016, the Contractor shall continue to conduct, for the affected MCO population, all scope of work items listed in Contract Exhibit A, including those items listed as ceasing effective April

1, 2016, for as long as deemed necessary. The prices for this mitigation plan will be a Monthly Fixed Fee and depend on the number of fully functional MCOs.

- Pricing below based on the assumption that three MCOs will manage the IA Health Link program.
    - If one MCO is not ready, then the total monthly Not to Exceed amount for this contract from April 2016 through June 2016 will be: $909,348.
    - If two or more MCOs are not ready, the parties shall work in good faith to identify and address impacts to scope, timing and fees, and execute an amendment to the contract.

Section 3: Ratification and Authorization

Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and that this Amendment constitutes a legal, valid, and binding obligation.

Section 4: Execution

IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Contractor, Telligen, Inc.	**Agency, Iowa Department of Human Services**
Signature of Authorized Representative:	Signature of Authorized Representative:
Printed Name: David Hancock	Printed Name: Charles M. Palmer
Title: Vice President	Title: Director
Date: 3-29-2016	Date: 4-8-16

Exhibit A to Amendment 23
{Replacement of RFP Section 6.2}

6.2 Medical Services

Medical Services includes an array of professional and medical activities to support Iowa Medicaid.

6.2.1 Medical Support

The medical support function includes policy development and consulting for specific service areas on behalf of the Department. The Medical Services contractor needs appropriately skilled medical and professional staff to respond to Department requests. These requests require professional advice on individual service requests for all areas of the program as well as recommendations on potential additions or changes to the existing coverage array for Medicaid. Data sources for the medical support function include the Department policy and provider manuals for Medicaid and procedure codes, prior authorization (PA) requirements and pricing files, all residing on the Iowa Medicaid Enterprise (IME) data systems.

6.2.1.1 State Responsibilities

a. Approve all policy for covered services under the Medicaid program.

b. Ensure that policy updates are made available to all affected contractors in a timely manner.

c. Schedule and provide administrative support for provider appeal hearings.

d. Make decisions regarding policy recommendations that the contractor suggests.

6.2.1.2 Contractor Responsibilities

a. Contractor shall:

1. Assure the Department that Iowa Medicaid policy reflects current medical practice.

2. Provide the Department with appropriate medical and professional expertise to evaluate any requests for new or unusual services or treatment modalities and their impact on current coverage policy.

3. Assure the Department that adequate medical or professional expertise is available to support administrative or court challenges to coverage decisions.

4. Assure the Department that decisions on individual service claims reflects current Iowa Medicaid policy, including claim prepay review, for those claims assigned by the Department, including:

(i) Manually reviewing claims requiring the determination of medical necessity or appropriateness and take appropriate action to adjudicate the claims, and

(ii) Consulting with Provider Cost Audits and Rate Setting contractor when medical judgment is needed for manual pricing of claims when no current fee or payment exists for the service.

b. Maintain the following interfaces:

1. MMIS for entering individual claims decisions, updating IME data systems and making Department-requested updates to provider records with new procedure codes or provider types or prior approval indicators to reflect policy changes, as well as maintenance of such policies.

2. through 3. Reserved.

c. Reserved.

d. Provide professional consultation services to the Department on requested changes to Medicaid services, whether from the Department, providers or other stakeholders. This responsibility includes drafting proposed policy clarifications or new policy regarding services covered under the Medicaid program.

e. Assist the Department in responding to appeals, provide written statements as well as testimony of medical and professional staff or consultants, as appropriate, to support decisions and participate in appeal hearings as requested by the Department. Provide administrative support in preparing for appeals.

f. Review exception to policy requests for the Bureau of Medical and LTSS Policy and make determinations for approval or denial of the request based on Department policies and procedures, cost-effectiveness, medical necessity, and the availability of lower cost alternatives. When necessary, request additional information from the requestor. Consult with bureau policy staff and other IME units as necessary, and prepare response letters for approval by bureau staff and signature by the Department director. Analyze trends in exception requests and make recommendations for Administrative Rule changes based on findings.

g. Provide professional and technical support to the Department in responding to program reviews and audits.

h. Perform the functions of a CMS-designated Quality Improvement Organization (QIO) or CMS-designated QIO-like organization on behalf of the Iowa Medicaid Program in accordance with 42 CFR 431.630.

i. Provide professional support to Medicaid providers regarding policy, prior authorization or billing requirements. This support may be in the form of oral instruction or written communication and must be documented in IME data systems.

j. Retain (on staff or in a consulting capacity) medical and social service professionals and other fields as deemed necessary by the Department. The consultants must be knowledgeable about the Iowa Medicaid Program's policies and procedures regarding coverage and limitations. These consultants provide consultation in the following areas at a minimum:

1. Anesthesiology
2. Audiology
3. Cardiovascular, vascular, and thoracic surgery
4. Child psychiatry
5. Chiropractic services
6. Dentistry
7. Disability services
8. Geriatrics
9. Family practice
10. Hematology
11. Medical supplies and equipment
12. Neurology
13. Obstetrics/gynecology
14. Occupational therapy
15. Oncology
16. Ophthalmology
17. Optical
18. Optometry
19. Organ transplant services
20. Orthodontics
21. Pathology
22. Pediatrics
23. Physical medicine
24. Plastic surgery
25. Podiatry
26. Psychiatry
27. Psychology
28. Radiology and nuclear medicine
29. Rehabilitation (physical therapy, occupational therapy and speech therapy)
30. Speech pathology
31. Developmental disability services (such as autism, Asperger disorder, brain injury and similar conditions)

k. Assure staff and/or consultants attend meetings with providers or other stakeholder groups in support of the Department programs and as requested by the Department.

l. Certify new outpatient hospital programs for appropriateness of Medicaid coverage and make recommendations to the Department regarding appropriateness of new programs; determine criteria to be used regarding coverage for new programs.

m. through p. Reserved.

q. Prepare for Department approval the CMS 64.96 Quarterly Report of Abortions, Hysterectomies and Sterilization, including supplemental worksheets relating to abortions and qualifications for federal funding.

r. through w. Reserved.

x. Provide support and technical assistance for any updates to the Minimum Data Set (MDS). Use MDS data to complete quarterly nursing facility case mix and submit Resource Utilization Group (RUG) scores to the IME Provider Cost Audit and Rate Setting (PCA) unit.

y. Provide medical support, coordination and facilitation for the clinical advisory committee (CAC). The committee members will represent all medical services providers. The committee will meet at a minimum quarterly and consist of seven to nine medical services providers. The IME medical services medical director will chair the CAC. Payment for pass-through costs shall be made as expenses are incurred as requested by the Department, which include but are not limited to quarterly meeting costs and ad hoc committee meetings for clinical advisory committee member attendance.

z. Provide the following reports:

1. Quarterly report of all appeal hearings, including status, disposition of case and recommendations for policy changes identified from appeals

2. Monthly report of exception to policy requests, including requestor, status disposition of request and recommendations for policy changes identified from requests.

3. Reserved.

4. An annual report summarizing activities of the CAC. The report shall be provided within 90 days of the state fiscal year end.

5. Reserved.

aa. through bb. Reserved.

cc. Provide support for the Payment Error Rate Measurement (PERM) Project by following up on all provider medical findings of overpayments and underpayments related to the PERM Project.

dd. Reserved.

ee. Provide administrative support as assigned by the Medicaid Director and policy staff including logging, assigning, and tracking all appeals and exception to policy requests for IME policy and vendor staff.

6.2.1.3 Performance Standards

a. Notify the provider within five business days of receipt of a claims inquiry with missing or incomplete information.

b. Send the final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.

c. Provide recommendations for exceptions to policy within eight business days of receipt unless additional information is requested. If additional information is needed, request it within two business days of receipt.

d. Complete 95 percent of Exception to Policy Determinations within 10 business days of receipt of complete information. Complete 100 percent within 20 business days.

6.2.2 Children's Health Care Prevention and Well-Child-Care Promotion

Children's Health Care Prevention and Well-Child-Care Promotion, which includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program benefits, is a proactive medical services program for members under the age of 21. Its goal is to prevent illness, complications, and the need for long-term treatment by screening and detecting health problems in their early stages. The EPSDT function supports the Department in the timely initiation and delivery of these services. The data sources for this function are:

a. Eligibility, claims, encounter and PA data from the Core MMIS

b. Input from the interdisciplinary team for the private duty nursing and personal care services provided to the special needs children under the EPSDT program

6.2.2.1 State Responsibilities

a. Provide policy interpretation and administrative decisions regarding EPSDT.

b. through c. Reserved.

6.2.2.2 Contractor Responsibilities

a. Reserved.

b. Maintain the following interfaces:

1. through 4. Reserved.

5. Child Health Specialty Clinic (CHSC) to provide a monthly electronic PA summary, including PAs on file for the next 6 months of authorized services for their clients. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor shall be paid for services performed pursuant to this subsection (b)(5) based on the hourly rate table set forth in Section 7.1 for hours approved in advance by the Department.

c. through d. Reserved.

e. Assemble and coordinate the service care planning and interdisciplinary team for the private duty nursing and personal care services provided to the special needs children under the EPSDT program. Contractor's obligations pursuant to this subsection (e) shall be limited to the fee-for-service population once managed care entities contracted pursuant to RFP MED-16-009 are implemented, which is anticipated to occur on April 1, 2016. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor shall be paid for services performed pursuant to this subsection (e) based on the hourly rate table set forth in Section 7.1 for hours approved in advance by the Department.

f. through l. Reserved.

6.2.2.3 Performance Standards

Reserved.

6.2.3 Medical Prior Authorization

Prior authorization (PA) of health services is a way of managing certain services and equipment provided to program members. The PA process includes several components:

a. through b. Reserved.

c. Adjudicating the actual requests for authorization

d. Enter the authorization to the claims payment system

The Medical Services contractor is responsible for providing qualified staff whose duties include verification of the medical necessity of specified services prior to provision of these services and other processes required to authorize payment for specified services. Inputs to the prior authorization function include hardcopy, telephone, facsimile, and electronic prior authorization requests. Effective with the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor shall be paid a unit price related to completion of each prior authorization as set forth in this Subsection 6.2.3, as set forth in Section 7.1 of the Contract, for those prior authorizations assigned by the Department.

6.2.3.1 State Responsibilities

a. Determine specific services requiring prior authorization and provide a listing to the Core MMIS contractor and the Medical Services contractor.

b. Provide written guidelines for prior authorization processing, including criteria for specific edits in the MMIS.

c. Monitor the Medical Services contractor's performance of the prior authorization function.

d. Contract with a CMS-designated QIO or CMS-designated QIO-like organization to perform prior authorization and preadmission review of selected services.

6.2.3.2 Contractor Responsibilities

a. Meet the following objectives:

1. Monitor services requiring prior authorization.

2. Control utilization of targeted services by providing a deterrent to inappropriate use.

3. Provide data to support management of services requiring prior authorization.

4. Process prior authorization requests, including pended, approved, modified, and denied.

b. The Medical Services contractor is responsible for processing the prior authorizations for the following types of services. Currently, this includes private duty nursing (EPSDT), personal care (EPSDT), certain dental services, DME, hearing aids, eyeglasses, certain medical services, psychological services, radiology, and swing beds.

c. Provide professional medical staff to perform prior authorization on certain services, including a full-time, on-site medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists,

dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals.

d. Staff and respond to the toll-free telephone line that providers (including LTC providers) call to determine the status of their PA request and handle all routine inquiries and correspondence regarding PAs. When a service requires PA, the provider submits the request to the Medical Services contractor's medical and professional staff. The Medical Services contractor staff reviews all requests for PA to determine whether the service to be provided is medically necessary and appropriate, determines whether the service should be approved or denied based on Department guidelines, and (if approved) determines an approved duration as required. When necessary, the medical and professional staff must attempt to obtain from providers additional information that is needed to adjudicate the PA requests.

e. Medical Services contractor staff may approve but cannot deny a PA request without first referring it to a peer consultant.

f. Accept PA requests on paper, by facsimile or electronically, in formats approved by the Department.

g. Accept PA requests from participating Medicaid providers, Department staff, or other sources determined by the Department.

h. Maintain PA requests and supporting documentation in the workflow management system that the Department provides. Hardcopy requests and documentation will be imaged by the Core MMIS contractor and be made available to the Medical Services contractor electronically.

i. Review all requests for prior authorizations that are required for services as well as prior authorization requests that providers submit when ambiguity exists as to whether a particular item or service is covered. Determine whether the service to be provided is medically necessary and appropriate and whether the service should be approved, denied or modified.

j. When necessary, attempt to obtain from providers additional information that is needed to adjudicate the PA requests.

k. Provide PA decisions through online updates to the MMIS by Medical Services staff.

l. Produce and send adverse action notices (NODs) on PA to the member indicating the reason and the circumstances for the adverse action, the appropriate section of the Iowa Administrative Code, information as to the specific reason for the denial that members would understand as the basis for denial and the right to appeal.

m. Send a copy of the Request for Prior Authorization form 470-0829 to the provider with the review decision. Do not list the identity of the consultant on the notice.

n. Reserved.

o. Ensure timely review of all requests and subsequent notifications to providers, pursuant to the Department performance standards. Automatically approve any PA request not acted on within 60 days of receipt (per the Iowa Administrative Code).

p. Reserved.

q. Obtain Department approval to support any request for review resulting from a decision reversed on appeal and involve Department policy staff as needed.

r. through t. Reserved.

u. Meet the PA file maintenance requirements, which include maintaining detailed audit trial reports of all changes to PA records, indicating date of last change, ID of the person making the change, and information changed for each PA record, and entering all requisite information regarding PAs in the MMIS.

v. Maintain a free-form text area on the PA record for special considerations, along with a flag to allow the system to identify authorizations with special considerations.

w. Reserved.

x. Edit PAs online, including:

1. Validation of provider ID and eligibility

2. Validation of member ID

3. Validation of procedure and diagnosis codes

4. Duplicate authorization check to previously authorized or previously adjudicated services (including denials) and duplicate requests in process

y. Maintain a process for prior authorizations of high-tech imaging (such as MRI, MRA, CT, and PET) for radiology services. The process requires prior authorization of high-tech imaging except in hospital and emergency room settings. Perform the medical review process and maintain Department-approved procedures for high-tech imaging that target variation in practice, promote cost-effective clinical decision making and increase the safety of Iowa Medicaid members.

z. Conduct prior authorization reviews for all swing bed admissions and continued stays, including determination of nursing facility or skilled nursing facility level of care, determination of appropriate number of days for authorization based on medical needs of the member, verification of swing-bed hospital provider efforts to locate appropriate alternative care within a 30-mile radius, and necessary monitoring of swing bed providers to assure discharge within 72 hours of an appropriate placement becoming available.

aa. Perform prior authorization for complex medical conditions and HCBS waiver services. For complex medical conditions, qualified licensed staff will review criteria approved by the Department to determine medical necessity for and duration of stays. For HCBS waiver services, qualified licensed and/or QMRP staff will review service plans requesting waiver services over the median amount utilizing criteria approved by the Department to determine medical necessity of requested amount, item or service. If medical necessity cannot be determined utilizing criteria, the case will be referred to peer review for service level determination.

bb. Perform prior authorization for behavioral health services. Qualified licensed staff will review criteria approved by the Department to determine medical necessity for and duration of hospital stays for persons to receive services addressing behavioral health concerns.

6.2.3.3 Performance Standards

a. Complete 95 percent of PA requests not requiring physician review, enter into system, and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.

b. Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.

c. For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

d. Review and make an HCBS PA determination within two business days of requests of initial service plans once all required materials are received.

e. Review and make an HCBS PA determination within five business days of request of continuing service plans once all required materials are received.

6.2.4 Long-Term Care (LTC) Reviews

The contractor will perform prescreening, admission, continued stay, quality and utilization reviews (URs) for identified LTC services. Various reviews will be

conducted for LTC programs including but not limited to nursing facility, intermediate care facilities for individuals with intellectual disabilities (ICF/ID), home and community-based services (HCBS) waiver programs, habilitation services, Psychiatric Medical Institution for Children (PMIC), Mental Health Institute (MHI), hospitals, out-of-state placements, and Program for All-inclusive Care for the Elderly (PACE) programs. The various reviews provide an objective and accurate evaluation of the individual's needs and are used to determine medical necessity and appropriateness of admissions to LTC services. The contractor will perform LTC reviews for members based on the Department guidelines.

With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations under this Section 6.2.4 shall be modified as follows:

- Contractor shall provide initial LOC reviews for all members (FFS and MCO) accessing an LTSS service for the first time.
- Contractor shall provide all subsequent stay reviews for the FFS population.
- Contractor shall provide subsequent stay reviews for any MCO member where the MCO determines the LOC has changed.

Beginning April 1, 2016, Contractor's compensation pursuant to this Section 6.2.4 shall be based on the fixed fee, unit, and hourly prices as set forth in Table 1 of Section 7.1 of the Contract.

6.2.4.1 State Responsibilities

a. Provide guidelines for staff qualifications of contractor staff conducting the assessment reviews.

b. Provide policy regarding the prescreening, admission, continued stay reviews, quality reviews and UR processes according to specific program guidelines.

c. Provide guidelines for an appeal process.

d. Monitor the performance of the LTC review processes.

e. Approve all LTC review edits and audits.

f. Approve all policies for covered services.

6.2.4.2 Contractor Responsibilities

a. Contractor shall:

1. Provide timely and objective functional eligibility decisions for LTC services.

2. Determine medical necessity and appropriateness of admissions to LTC services.

3. Provide information to members and families as directed by the Department.

4. Determine continued medical necessity and appropriateness for LTC services.

b. Provide professional medical staff to perform the LTC reviews on all members who apply for LTC services. The type and qualifications of the staff must be approved by the Department.

c. Conduct level of care determinations (initial and continued stay reviews) in accordance with all state and federal requirements for applicants requesting Medicaid funding for facility services (nursing facility, ICF/ID, PMIC) or review- based services (HCBS waivers, PACE), habilitation, and other services as requested by the Department.

d. through f. Reserved.

g. Conduct quality reviews in accordance with all state or federal requirements of habilitation and HCBS waiver programs, as approved by the Department and other services as requested. Coordinate the reviews with other contractors and state staff. The quality reviews evaluate level of care needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans. The results of these reviews need to be at a satisfactory level as evidenced by:

1. Services are individualized and reflect member's preferences and needs.

2. Services are implemented as planned and produce the desired results.

3. Members are safe and secure.

4. Members are free to exercise their rights.

5. Services strive to improve quality outcomes for members.

h. Conduct UR activity in accordance with 42 CFR Part 456.
1. For ICF/ID, NFMI, PMIC and MHI, the purpose of the annual on-site review is to evaluate the appropriateness of placement and that services are meeting the treatment needs of the members.

2. For hospitals, conduct a desk review every three years of each hospital's utilization control processes to assess their comprehensiveness and verify their completion.

i. Notify providers of the results of the LTC reviews:

1. Reserved.

2. URs for ICF/MR, NFMI, PMIC, MHI, and hospitals

3. Quality reviews for HCBS and habilitation

j Update IME data systems with the results of the LTC reviews within the timeframes specified in the performance standards.

k. Respond to phone calls from members on the questions or status of admission and continued stay reviews within two business days.

l. Conduct annual on-site MDS validation reviews on 25 percent of Medicaid-eligible residents in each of Iowa's certified NFs. The review will ensure a minimum inter- rater reliability of 95 percent. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (l) shall cease.

1. The sample shall include a representative from each RUG category, with a minimum of 40 percent of the sample being residents identified in the physical function reduced case mix category.

2. The on-site validation review will utilize all pertinent information, including the MDS, the member's medical record, interviews with facility staff and observation of the resident.

3. Conduct exit conference with the NF administrative staff to identify inconsistencies found in the MDS fields utilized for RUGs III classifications. The exit conference shall include MDS assessment with patterns of errors, areas that need improvement, staff education and training needs, and notice of when the final report will be sent to the facility.

4. Provide formal written report of the MDS validation process.

5. If a facility has an error rate greater than 25 percent, the review shall be increased to include an additional 25 percent of the Medicaid members. Notify the Department if a nursing facility's error rate is greater than the established threshold or questionable patterns of coding or transmission are noticed.

6. Provide qualified and trained staff to perform the MDS validation reviews. The Department must approve the guidelines for the type and experience level of proposed staff.

m. Reserved.

n. Operate a quality assurance and compliance monitoring plan for the PACE providers in accordance with 42 CFR, Part 460.

1. In cooperation with CMS and the Department for newly established PACE programs, provide adequate staff to complete the initial technical assistance review.

2. Conduct at least one unscheduled quality review on site annually utilizing the quality review process developed by CMS.

3. In cooperation with CMS and the Department, participate with adequate staff in the annual reviews of the PACE organization during the three-year trial period and biannually thereafter.

4. Write reports utilizing CMS format.

5. Monitor and follow up to ensure corrective actions will be implemented.

6. Submit reports to the Department within 30 business days.

With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor shall be paid for services performed pursuant to this subsection (n) based on the fixed fee set forth in Table 1 of Section 7.1 of the Contract.

o. through p. Reserved.

q. Prepare and submit to the Department the following:

1. Report on the members approved and denied for LTC services based on assessments and reassessments using Department-approved criteria

2. Reports of appeal activity with fiscal year-to-date totals with trending and recommendations for improvements

3. Reserved.

4. Quarterly report of MDS validation review activity and findings. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (q)(4) shall cease.

5. Submit monthly HCBS PA activity reports within 10 business days from the end of the month of activity.

6. Submit quarterly HCBS PA cost savings report within 10 business days from the end of the quarter of activity, to document the savings achieved for each waiver. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (q)(6) shall cease.

r. Provide reports to the Department as identified in a Department-approved format within 30 business days of completion of the on-site quality reviews and URs. Forward to the Department of Inspections and Appeals (DIA) upon receipt of Department approval. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (r) shall cease.

s. Provide a written report to the provider that includes the evaluation of the ICF/ID, NF/MI, PMIC, MHI and hospital UR plan compliance and recommendations for enhancements, corrective action or both within 30 business days of completion of the on-site visit. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (s) shall cease.

t. Provide written report on the findings of the quality assurance and compliance monitoring of PACE providers and recommendations, corrective action or both within 30 days of completion of the review.

u. Reserved.

v. Develop and implement a process in accordance with new Federal requirements of the Minimum Data Set (MDS) 3.0 Section "Q". Contractor will receive calls from nursing facilities reporting a resident (regardless of pay source) who identifies he or she wants to talk with someone about the possibility of returning to the community. Following the intake calls, Contractor will make a referral to the Local Contact Agency (designated by the IME) for options counseling and possible transition planning.

w. Complete initial assessments necessary for determination of level of care for children who have applied for the Intellectual Disability (ID) Waiver. Assessments will be completed using a form determined by the Department within 2 business days of receiving all necessary information from the referring case manager, including a complete psychological evaluation. With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to this subsection (w) shall cease.

x. Reserved.

y. Conduct reviews to identify short-stay approvals for members seeking admission to a Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facilities for Persons with an Intellectual Disability (ICF/ID) from an acute setting when

the prior living arrangement was a community setting. Complete reviews for continued stay to ensure that facility placement is for the shortest duration possible, allowing members who choose to return to the community to do so at the earliest possible opportunity.

6.2.4.3 Performance Standards

a. Complete 95 percent of level-of-care (LOC) determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.

b. Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

c. Conduct annual on-site UR visits between months 10 and 12 following the prior year visit to ICF/ID, nursing facility for the mentally ill (NF/MI), PMIC and MHI facilities.

e. through f. Reserved.

g. Reserved.

h. Reserved.

6.2.5 Quality of Care

With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to Section 6.2.5 and all of its subparts shall cease. Thereafter, Contractor shall:

a. complete all outstanding EQR reviews;
b. complete remaining retroactive special authorizations for MediPASS, quarterly referral authorization verifications for MediPASS, and quarterly assurance paid claims audits for MediPASS by March 31, 2016; and
c. provide any reports associated with the Scope of Work as set forth in Section 6.2.5, as directed by the Department.

The quality of care (QOC) function is designed to monitor the care provided to Iowa Medicaid members. The Medical Services contractor is expected to focus on the three managed care programs as the basis for this quality function. The managed care programs include MediPASS (a primary care case management system), the HMO network (if any) and the Iowa Plan for behavioral health. The contractor will use monitoring programs in place in the Medicaid program today as a base but will be expected to design a comprehensive report card that looks at quality of care across all managed care programs under Medicaid.

The primary data source will be claims and encounter data from the data warehouse. The MMIS will provide information on capitation payments and providers. The managed care providers will provide information on provider panels and access.

6.2.5.1 State Responsibilities

a. Provide current policy requirements for member access and quality standards, to the extent available.

b. Provide quality and access requirements for HMO, MediPASS and Iowa Plan contracts.

c. Facilitate access to HMO, MediPASS and Iowa Plan contractors.

d. Provide policy direction to contractor in defining components of federally approved quality plan.

6.2.5.2 Contractor Responsibilities

a. Meet the following objectives:

1. Determine the status of Medicaid program contract providers' compliance with service agreements.

2. Determine health status of Medicaid members, to the extent information is available through assessment tools such as HEDIS.

3. Design a process for measuring overall health status of Medicaid members.

b. Perform technical analyses, data collection and reporting on the performance of the HMOs (if any) in the Iowa Medicaid Program. This responsibility includes:

1. Ensuring that federal requirements for managed health care contracting are met

2. Assisting the Department in the preparation of any managed health care waivers necessary to operate the program

3. Ensuring the HMOs' provider panel adequacy
The Department will provide the Medical Services contractor with a quarterly report of the HMOs and their enrolled providers. The Medical Services contractor will perform a quarterly review of the HMO provider panel data to assure each HMO is adequately serving the number of enrollees based on the number and type of providers enrolled with the HMO. The findings are reported to the Department.

4. Participating in any federal reviews, as necessary.

5. Conducting and reporting on appointment surveys

6. Performing call center and quality assurance/utilization review (QA/UR) functions

7. Providing medical expertise for review of appeals that occur subsequent to an adverse action by the health plans

8. Ensuring that providers are adequately trained and understand all QA/UR systems, grievance procedures and grievance resolution

9. Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter-based data

10. Sponsoring and participating in biweekly meetings with the Department and the
HMOs

11. Providing meeting minutes for approval to the Department

c. Perform UR, quality assurance, grievance resolution, data collection, technical analysis, and reporting for the HMOs and MediPASS providers. Specific data to be collected and analysis performed will be negotiated between the contractor and the Department. Report all analysis outcomes, including but not limited to MediPass access issues, providers not making enough referrals or providing services, and member-reported quality of care issues.

d. Evaluate adequacy of provider panels for the contracted Managed Care Organizations (MCOs)

e. Verify compliance by MediPASS providers with requirements for 24-hour coverage for assigned Medicaid members.

f. Perform quality assurance, UR, and grievance resolution for the Iowa Plan participants, which include:

1. Ensuring that federal requirements for managed health care contracting are met

2. Assisting the Department in the preparation of any managed health care waivers necessary to operate the program

3. Ensuring the Iowa Plan's provider panel adequacy. The Department will provide the Medical Services contractor with a quarterly report of the Iowa Plan enrolled providers. The Medical Services contractor will perform a quarterly review of the provider panel data to assure the Iowa Plan is adequately serving

Medicaid members. The findings are reported to the Department.

4. Participating in any federal reviews, as necessary

5. Conducting and reporting on appointment surveys

6. Performing call center and QA/UR functions

7. Providing medical expertise for review of appeals that occur subsequent to an adverse action by the health plans

8. Ensuring that providers are adequately trained and understand all QA/UR systems, grievance procedures, and grievance resolution

9. Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter-based data

g. Design, in conjunction with the Department, a report card to provide a qualitative assessment of the MCOs in the Iowa Medicaid Program. The contractor must have a test version of such an instrument ready for use by the beginning of the second year of operation.

h. Collaborate with and provide requested data and other information requested by the External Quality Review (EQR) contractor on behalf of the IME.

i. Accept referrals from other IME units regarding continuity of care issues from managed care enrollees. With referral, begin the special authorization process.

j. Complete EQR report as required by CMS following each on-site MCO audit. Perform EQR audits to comply with CMS-mandated regulations and protocols requiring external evaluations of the quality and utilization processes for MCO systems. These reviews are performed for the MCOs contracted as Medicaid providers in Iowa.

j. Provide quarterly quality assurance and UR reports to MediPASS providers.

k. Provide quarterly paid claims audits of MediPASS enrollees.

l. Use the Department's data warehouse as the primary source for claims and encounter data. The Medical Services contractor will also need to obtain HEDIS information from the EQR contractor, and may need performance measures from HMO contractors, either from Department staff or through the claims processing contractor.

m. Provide recommendations to the Department for further investigation.

6.2.5.3 Performance Standards

a. Provide quarterly reports within 10 business days of the end of the reporting quarter.

b. Submit EQR report to the Department within 45 business days of the on-site audit of a managed care organization.

6.2.6 Health Information Technology

Support activities based on provisions in the American Recovery and Reinvestment Act (ARRA) and in compliance with Federal regulations outlined in 42 CFR 495. Research, plan and oversee the HIT project, including initiatives supporting the meaningful use of health information exchange and coordination with the Health Information Exchange (HIE) and the Regional Extension Center. Ensure privacy and security in expanding the availability of health information exchange. Identify connection points between the health information exchange and the MMIS system for administrative efficiencies and program evaluation. The Department has developed a State Medicaid Health Information Technology Plan (SMHP) that provides the vision and roadmap to encourage the adoption and meaningful use of electronic health records systems by Iowa Medicaid providers. This strategic plan will be reviewed and updated annually to allow Iowa Medicaid to leverage technology to improve quality outcomes and manage the growing costs of health care delivery.

6.2.6.1 State Responsibilities

a. Provide current policy, status and lines of communication regarding the HIT plan, Affordable Care Act planning and subsequent projects.

b. Set direction for contractor as planning efforts mature.

c. Establish and communicate the project library for each project.

6.2.6.2 Contractor Responsibilities

a. Manage the continuing development of the HIT plan as directed by the Department.

b. Represent the Department in discussions with stakeholders.

c. Protect the privacy of Medicaid members in all recommendations.

d. Contribute to the definition of incentive payment strategies.

e. Champion the plan within the Medical Services unit as the plan matures and features of the plan are enacted.

f. Participate in planning and execution of statewide provider assessment as directed by the Department.

g. Provide consolidated project tracking and reporting for all Health Information Technology projects.

h. Provide weekly status reports regarding HIT project(s) status, items completed, work planned for the next week (including meetings), outstanding action items and issues

i. Update the State Medicaid HIT Plan annually and as needed for new initiatives.

j. Update the HIT I-APD annually and as needed.

k. Provide HIT I-APD budget planning and tracking.

l. Provide quarterly update reports for CMS regarding progress on the HIT I-APD.

m. Participate in the HIT Regional Extension Center advisory council as directed by the Department.

n. Participate in the Iowa e-Health advisory council and workgroups as directed by the Department.

o. Represent Iowa Medicaid Enterprise in presentations and workshops related to Health Information Technology as directed by the Department.

p. Attend regional and national conferences related to Health Information Technology as directed by the Department, including the Annual CMS HITECH conference and ONC HIT Grantee conference.

q. Schedule and facilitate monthly status meetings with the project steering team and Provider Services Unit Manager.

r. Support and track projects related to Health Information Technology as directed by the Department. Currently known projects include:

1. Jointly host an annual e-Health Summit conference with Iowa eHealth and the HIT Regional Extension Center
2. Medicaid members access to personal health records
3. Application of HIT to reduce costs and/or improve quality outcomes
4. Program evaluation and environmental scans

s. Maintain a project library that includes the project deliverables, links to relevant resources, and supporting research.

t. Document and place in project library all meeting minutes following all meetings with internal and external entities and/or project meetings in which decisions were made or actions items assigned.

u. Participate in annual reviews and updates of the SMHP as directed by the Department.

v. Participate in local, regional and national conferences as directed by the Department.

w. Recommend strategies to leverage the availability of clinical data to promote efficiencies and improve clinical outcomes.

x. Manage the capture of quality metrics for the purposes of measuring meaningful use of electronic health records, health/medical home performance monitoring, federal reporting, or other Medicaid program evaluation purposes.

y. Produce and update the following deliverables for each project, within the timelines agreed upon by the Department:

1. Project Charter – including the project scope
2. Cost Benefit Analysis
3. Business Requirements
4. Project Plan
5. Test Plan
6. Implementation Plan

6.2.6.3 Performance Standards

a. Contractor shall participate in 90% of HIT project status meetings.

b. Contractor shall submit weekly project status reports by 9:00am Monday mornings.

c. Contractor shall deliver project documents within the timeframes agreed upon between the Contractor and the Department in the project charter.

d. Contractor shall update the project work plan at a minimum every 21 calendar days.

6.2.7 Medical Home Program

Contractor shall assist in the development of Iowa's Medical Home Program as directed by Senate File (SF) 2356 (IowaCare), House File 2539 (Pediatric Medical Home), CMS Multi-payor Medical Home Demonstration, and Section 2703 of the Patient Protection and Affordable Care Act (PPACA).

The Medical Home program will promote accessible and continuous care that is coordinated, comprehensive, family-centered, compassionate and culturally effective.
The Medical Home Program's focus will be to build a more robust primary care delivery system to maximize prevention and effective treatment of chronic care, minimize uncoordinated care and duplication of efforts, and avoid preventable use of hospitals and emergency departments.

6.2.7.1 State Responsibilities

a. The Medical Home programs will have a phased in implementation as determined by the Department.

6.2.7.2 Contractor Responsibilities

a. Research other state Medicaid medical home models and implementation strategies.
b. Draft development and implementation plan for the Iowa Medical Home program.
c. Facilitate primary stakeholder understanding and buy-in on the Medical Home program.
d. Draft reimbursement and incentive methodology to ensure care coordination and quality care are part of the Medical Home program.
e. Develop performance indicators to identify effective Medical Homes for incentive payment.

6.2.7.3 Performance Standards

a. Meet the Department's established timelines for implementation of Medical Home (IowaCare Expansion Medical Home - 10/2010; Pediatric Medical Home - to be determined; Adult Medical Home - to be determined).

6.2.8 ICD-10

The contractor will provide medical expertise to support the policy and business level efforts to achieve strategic implementation of the transition to Version 10 of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) project. The contractor will provide medical management, clinical expertise, and analysis throughout the project.

6.2.8.1 State Responsibilities

a. Facilitate access to policies and computer systems
b. Monitor contractor performance of duties

6.2.8.2 Contractor Responsibilities

a. Provide project leadership for the Medical Services unit for the ICD-10 implementation
b. Participate in ICD-10 project planning and monitoring activities
c. Provide staff expertise to review ICD-10 codes and develop mapping and translation between ICD-9 and ICD-10 for all systems and policy modifications
d. Create business requirements for process and system modifications
e. Develop Master and detail test plans and scripts
f. Execute tests and report the results
g. Report issues or bugs to the project and development teams
h. Respond to questions regarding clinical translations of information
i. Participate in ICD-10 project activities as directed by the project manager or project director

j. Transfer knowledge to the appropriate IME staff

6.2.8.3 Performance Standards

a. For all project deliverables (including business requirements, bi-directional code mappings, master and detailed test plans) the contractor must obtain the Department's acceptance of deliverables within 2 days of the project schedule (exceptions may be granted by the unit manager, ICD-10 project manager, or ICD-10 project director).
b. All deliverables must meet the standards established by DHS.
c. Provide status reports as scheduled by DHS.

6.2.9 IHAWP and ELIAS Interface Testing

With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to Section 6.2.9 and all of its subparts shall cease effective April 1, 2016.

The Contractor shall provide a dedicated IT testing group to support implementation of activities of both the Iowa Health and Wellness Plan (IHAWP) and Iowa's Eligibility Integrated Application Solution (ELIAS).

Contractor's efforts shall ensure that eligibility groups are enrolled, claims adjudicated, and federal reporting completed for both the existing eligibility groups and the new eligibility groups.

6.2.9.1 State Responsibilities

a. Facilitate access to policies and computer systems.
b. Monitor contractor performance of duties.

6.2.9.2 Contractor Responsibilities

Contractor shall:
a. Contractor shall complete eligibility and enrollment testing according to the dates established in the Agency-approved project plan.
b. Contractor shall complete claims testing and reporting according to the dates established in the Agency-approved project plan.
c. Contractor deliverables shall meet the standards established by the Agency.

6.2.9.3 Performance Standards

a. Contractor shall complete eligibility and enrollment testing at least five (5) business days before October 1, 2013, contingent upon prior Agency completion of ELIAS and other systems work.
b. Contractor shall complete claims testing and reporting at least five (5) business days before January 1, 2014, contingent upon prior Agency completion of ELIAS and other systems work.
c. Contractor deliverables shall meet the standards established by the Agency.

6.2.10 IHAWP Operations

With the implementation of managed care entities contracted pursuant to RFP MED-16-009, anticipated to occur on April 1, 2016, Contractor's obligations pursuant to Section 6.2.10 and all of its subparts shall cease effective April 1, 2016.

The Contractor shall support operations of the Iowa Health and Wellness Plan ("IHAWP").

6.2.10.1 State Responsibilities

a. Provide policy direction and administrative decisions regarding the project as planning efforts mature.
b. Monitor the Contractor's IHAWP Operations performance.

6.2.10.2 Contractor Responsibilities

Contractor duties include but are not limited to:
a. Provide 4.5 FTE new staff, to be designated by title, to work exclusively in addressing IHAWP Operations.

6.2.10.3 Performance Standards

a. Contractor shall comply with all Performance Standards outlined in Section 6.2 in relation to services provided pursuant to subsection 6.2.10.

6.2.11 State Innovation Models

Based on the specific needs within Iowa's State Innovation Models (SIM) Testing Cooperative Agreement proposal, the Contractor shall provide subject matter expert support to the Agency in implementing and testing a multi-payer value-based purchasing model.

6.2.11.1 State Responsibilities

Agency staff will:
a. Provide policy direction and administrative decisions regarding the project as SIM testing efforts mature.
b. Review and approve all grant deliverables including the SIM Operational Plans, SIM Quarterly Activity reports, and SIM Budget revisions.
c. Participate on SIM Leadership and other stakeholder outreach activities to promote the SIM initiative.

6.2.11.2 Contractor Responsibilities

a. Project Management and Oversight. Contractor shall designate one project director, two project managers, and one project assistant who will be dedicated full time to the SIM project. Contractor shall act on behalf of the State to manage and oversee all project-related activities and milestones, including providing direction and guidance to state and

contracted staff, to mitigate risk, resolve issues, and successfully plan, implement, and monitor the SIM Test grant project.

b. Contractor project director duties include but are not limited to the following:
    1. Create and maintain a Project Work Plan (PWP). The PWP shall define all tasks and deliverables covering the SIM Cooperative Agreement, and incorporate all other contracted staff work plan milestones.
    2. Create and maintain a communications plan that incorporates, at minimum, stakeholder engagement and communication strategies.
    3. Implement monthly, quarterly, and as needed status reporting to the Agency, outlining progress on deliverables as defined in the Agency-approved PWP.
    4. Establish the project management structure and tools that allow monitoring of work plans, resolution of issues, and mitigation of risk. Interdependencies within each project shall be identified and prioritized. Necessary elements include but are not limited to:
        i. A reporting structure that identifies risks that affect time, cost, or performance constraints on the project.
        ii. Walkthroughs of deliverables as needed to seek Agency approval and timely submission of grant deliverables.
    5. Facilitate the development and maintenance of SIM project vision, mission, goals, objectives and a driver diagram with SIM leadership team.
    6. Identify changes needed to the MMIS and other Medicaid infrastructure tools and ensure those changes were appropriately and timely made. Contractor shall maintain a detailed written log and store in a location available to Agency staff.
    7. Identify impacts and coordinate activities with other healthcare initiatives (e.g., BIP, ICD-10, HIT/HIE, PPACA, Managed Care, and ELIAS). Identify recommended solutions to known issues.
    8. Participate in the Agency's healthcare project coordination committee.
    9. Prepare assessment of impacts and risks of the SIM project on the other Agency defined major healthcare initiatives and recommended solutions to issues as they become known.

c. Contractor PMO duties include but are not limited to the following:
    1. Review and report on all project work plans of any vendors having roles in the project. This includes the new SIM project vendors as well as current IME vendors. Facilitate corrective action plans for those plans not found to be acceptable.
    2. Monitor all SIM and IME contractors' progress towards implementation goals and identify risks, timeline, cost, or performance of the project including but not limited to the in-state evaluator, the analytic vendor, Iowa Department of Public Health and subcontractors.
    3. Report on overall implementation readiness for each planned phase of the project.
    4. Prepare and present status updates periodically to CMS, the Agency, and other stakeholders as requested by the Agency.
    5. Facilitate the Executive teams (Core Planning Team, Leadership Team and Agency Sponsors) with management activities including development and implementation of key documents and executive meetings.

6. Execute the approved stakeholder engagement plan by scheduling and conducting stakeholder meetings at least bi-annually, with SIM Leadership, and with the MAAC. The Contractor shall engage other stakeholders as deemed necessary by the Agency, at a frequency approved by the Agency and documented in the approved stakeholder engagement plan.
7. Support the development of value-based purchasing (VBP) within the Medicaid population using a MCO as the delivery system. Support includes, but is not limited to:
    i. Developing a VBP transition plan that is aligned with the Agency's transition into Medicaid MCOs.
    ii. Facilitate the development of VBP MCO scorecard that aligns with the objectives of the SIM Test.
8. Support the collection of and reporting of SIM activities and SIM outcomes to various levels of leadership and stakeholders as agreed upon by the Agency.
9. Document the project through an indexed project library that includes meeting agendas, meeting notes, decision documents and any other relevant aspects of project activities of the SIM project so that a clear, concise record of all elements is created as a historical reference.
10. Develop and maintain a SIM Webpage designed to inform and engage stakeholders outside of the Agency on SIM activities and outcomes.

6.2.11.3 Performance Standards

a. Unless otherwise identified, the Contractor shall provide all identified deliverables in an Agency-approved format and in accordance with timeframes established in the Agency-approved work plan.in accordance with timeframes established in the Agency-approved work plan

b. **Project Work Plan (PWP):**

1. Contractor shall submit an initial PWP to the Agency for approval within 20 days of Contract execution. Contractor shall submit a comprehensive PWP for Agency approval no later than October 1, 2015. Contractor must receive final approval of the PWP within 10 calendar days of submission of the initial and comprehensive PWPs.
2. For those plans found not to be acceptable, Contractor shall submit weekly written reports to the Agency identifying each contractor's work plan status, the identified risks and corrective actions, and an assessment of the impacts of those risks and other known issues.

c. **SIM Vision, Mission, Goals and Objectives:**

1. Contractor shall format and deliver the SIM vision statement, mission statement, goals, objectives and a driver diagram developed by SIM Leadership team to the Agency for approval by October 1, 2015.

d. **Meeting Facilitation:**

1. Contractor shall facilitate all SIM leadership meetings. This includes and is not limited to agenda preparation, recording of minutes and follow-up actions. A record of all meetings is to be maintained on the SIM website;
2. Contractor shall distribute executive meeting agendas at least two (2) business days prior to each meeting.
3. Contractor shall distribute executive meeting notes within two (2) business days of the conclusion of the meeting.

e. **Stakeholder Engagement and Communication Management:**

1. Contractor shall submit the communications plan to the Agency within 30 days of Contract execution.

f. **Contractor Management:**

1. Contractor shall manage all SIM vendor contracts and submit reports to Agency detailing vendor performance.

g. **Reporting Management:**

1. Contractor shall submit a project library outline to the Agency for approval prior to implementation of the project library and within 10 days of Contract execution.
2. Contractor shall submit at minimum written quarterly status reports to the Agency. These reports will include identification of all project issues, vendor status updates, corrective actions, and resolutions.
3. Contractor shall submit written quarterly reports in a format defined by CMS and by the 15th of the month following the last day of the quarter. Contractor must receive final approval within 10 calendar days of first submission. Contractor must comply with all CMS grant reporting requirements and timelines.
4. Contractor shall submit ad hoc status updates, presentations and reports to Agency and Stakeholders at intervals as defined by the Agency. Such updates and presentations will be professional, accurate, and give the intended audiences a clear, accurate picture of the project's status.
5. Contractor shall include the Agency in all correspondence required by CMS and maintain and inventory of CMS Communication activity on an ongoing basis.

h. **Decisions Management:**

1. Contract shall ensure that at least 95% of recommended resolutions and risk mitigations result in successful resolution and return to execution of the Agency-approved work plan.
2. Contractor shall submit written documentation of all major decisions to the Agency for approval within one (1) business day of the decision(s). Once

approved by the Agency's representative, the Contractor shall distribute the decisions and post in the project library.

6.2.12 Medicaid Modernization Support

For the time period of April 1, 2016 through June 30, 2016, Contractor shall provide support of the Medicaid modernization effort underway at the Agency. This effort is expected to "go live" April 1, 2016. If the "go live" date is delayed in whole or in part, the parties agree to work in good faith to identify and address impacts to scope, timing and fees, and execute an amendment to the Contract equitably addressing the impacts.